OPIOID PRIOR AUTHORIZATION (PA) FORM

The MCOs/FFS below use this form for the Opioid PA. For other MCOs' forms please visit:
https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/pa-information.aspx

Completed forms should be faxed to the number corresponding to the patient's plan.

MCO	Plan Name	Telephone	Fax
aetna®	Aetna Better Health of Maryland (ABHM)	(866) 827-2710	(877)-270-3298 www.aetnabetterhealth.com/maryland

INSTRUCTIONS

ALL prescribers must complete SECTION 1*, SECTION 2, and SECTION 3.

Prescribers must also complete SECTION 4 or SECTION 5, as appropriate.

To **AVOID DELAYS** in processing this request, please ensure **CONTACT INFORMATION** below is **ACCURATE** in case **ADDITIONAL INFORMATION** is **REQUIRED**. Duration of PA is determined by Medicaid FFS or MCO.

For additional information regarding individual MCO opioid prescribing requirements go to:
https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/pa-information.aspx
and select the appropriate MCO for more information.

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SECTION 1: DEMOGRAPHICS

Date: _____

Patient Name: _____

MCO Plan ID#: _____ [Required for AG, UMHP, KP, MFC]

MD Medicaid ID#: _____ [Required for ABHP, FFS, JMS, MPC, PP]

Date of Birth: _____ Gender as listed by the patient: ☐ Male ☐ Female

Name of MCO: _____ Other Insurance? _____

Prescriber Name: _____ Prescriber NPI#: _____

Prescriber DEA#: _____ Phone for Prescriber: _____

Office Contact Name/Fax Attention to: _____

Office Contact Direct Phone#: _____ Office / Prescriber Fax#: _____

Facility / Clinic Name (if applicable): _____

SECTION 2: PLEASE CHECK THE BOX THAT APPLIES

☐ Non-Urgent Review

☐ Urgent Review: By checking this box, I certify that applying non-urgent review timeframe may lead to patient harm.

☐ Yes ☐ No This patient is currently an inpatient at an acute care hospital

☐ Yes ☐ No Is this patient being discharged from the hospital or ED?

☐ Yes ☐ No Is the patient pregnant? *(See references below)*

http://www.medscape.com/viewarticle/867512
https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm
https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm118113.htm?source=govdelivery
https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm

SECTION 3: USE A SEPARATE FORM FOR EACH MEDICATION BEING REQUESTED

Select One: ☐ New Prescription ☐ Refill (i.e., patient has been taking medication)

Diagnosis: _____

Select All That Apply:

☐ Immediate-Release Opioid ☐ Extended-Release Opioid ☐ Fentanyl ☐ Methadone *(for pain)*

☐ Exceeds 90 MME/day ☐ Exceeds Tablet Quantity Limit (Maximum Daily Limit)

If 90 MME/day or Quantity Limit is exceeded, provide rationale: _____

_____

_____

☐ Non-Formulary/Non-Preferred. If selected, complete information within table below.

Previous Formulary Trial(s)		
Drug Name/Strength/Dose	Date(s) & Duration of Trial	Treatment Outcome

Drug Requested:

Drug Name: _____ Strength: _____ Quantity: _____

SIG: _____ Length of Treatment: _____ ☐Day(s) / ☐Month(s)

SECTION 4: FOR EXEMPT PATIENTS ONLY

☐ Yes ☐ No **Active Cancer Treatment** Cancer Type: _____
☐ Yes ☐ No **Sickle Cell Disease**
☐ Yes ☐ No **Hospice Care** Diagnosis: _____
☐ Yes ☐ No **Palliative Care** [(Diagnosis Code (Z51.5)] Diagnosis: _____
☐ Yes ☐ No **Long-Term Care / Skilled Nursing Facility**

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature: _____ Date: _____

Important: *The remainder of this PA form* ***does not need to be completed*** *for patients who meet at least one of the above exemptions.*

SECTION 5: ATTESTATION REQUIRED OF ALL PRESCRIBERS FOR NON-EXEMPT PATIENTS
[Choose the one section (A. or B.) that applies]

A. For Outpatient Prescribers providing ongoing care:
EACH Question Must Be Answered

☐ Yes ☐ No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
☐ Yes ☐ No Patient has/will have random Urine Drug Screens (UDS).
☐ Yes ☐ No Naloxone prescription was provided or offered to patient/patient's household.
☐ Yes ☐ No Patient-Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record.

B. For Inpatient Hospital (Hospital), Ambulatory Surgery Center (ASC), and Emergency Room (ER) Prescribers:
EACH Question Must Be Answered

☐ Yes ☐ No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
☐ Yes ☐ No Naloxone prescription provided or offered to patient/patient's household.
☐ Yes ☐ No I have discussed the risks/benefits associated with opioid use with patient/patient's household.
☐ Yes ☐ No The patient is exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random UDS, because he/she is being discharged from the Hospital/ASC/ER and opioid treatment prescribed by the discharging provider will be for less than 30 days ***or*** the need for further opioid use will be re-evaluated by an Outpatient provider within 30 days.

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature: _____ Date: _____

Important: *Incomplete attestations will not be able to be processed by Medicaid FFS or MCO and will delay requests.*

For Internal Use Only. Duration of Approval: _____ Authorized By/Date: _____